In Re: Asbestos Products Liability Litigation (No. VI)

MDL DOCKET NO. MDL 875

Transcript of the Testimony of:

Thomas Wiig, M.D.

November 23, 2015

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IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

GARY SUOJA, Individually and as Special Administrator for the Estate of OSWALD F. SUOJA,

Plaintiff,

vs. Case No: 3:99-cv-00475-bbc

OWENS-ILLINOIS, INC.,

Defendant.

DEPOSITION OF THOMAS WIIG, M.D.

Taken on November 23, 2015

at

Essentia Health

503 East Second Street

Duluth, Minnesota

COURT REPORTER: Karen J. Macaulay, RDR

Deposition of THOMAS WIIG, M.D., taken in the above-entitled matter before Karen J. Macaulay, a Notary Public, at Essentia Health, 503 East Second Street, Duluth, Minnesota, commencing at 2:13 p.m. on November 23, 2015.

APPEARANCES:

CASCINO VAUGHAN LAW OFFICES, LTD., by
Robert G. McCoy, Esq. (By Telephone)
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Appeared on behalf of the Plaintiff.

SCHIFF HARDIN LLP, by
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Appeared on behalf of the Defendant.

I N D E X

DEPONENT: THOMAS WIIG, M.D.

EXAMINATION:	PAGE:
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Objections:

By Mr. Watson: 7, 10, 11, 12, 14, 16, 17, 18, 20, 21, 22, 29, 30, 31, 35, 84

By Mr. McCoy: 52, 81

Requests: None

Instructions Not to Answer: None

Dr. Wiig Exhibits Marked:

Exh. 1	Curriculum Vitae	86
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Exh. 4	Medical Records	41

(Original exhibits attached to original transcript; copies of exhibits attached to copies of transcript)

NOTE: The original transcript is filed with Attorney McCoy.

(Dr. Wiig Exhibit 2 was marked for identification.)

THOMAS WIIG, M.D.,
called as a witness, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. McCOY:

Q. Doctor, I'd like you to begin and introduce yourself and give us your full name and spell your last name.

A. Thomas H. Wiig, W-i-i-g.

Q. And what is your -- you're a medical doctor. Right?

A. That's correct.

Q. Okay. What is your present position, Dr. Wiig?

A. My present position at Essentia Health is as Chief Medical Informatics Officer.

Q. And how long have you held the position as Chief Informatics Officer?

A. Four years.

Q. Did you have other positions as a practicing physician before that time?

A. Yes, between -- I started at Essentia Health in 1981 and held a position of general surgeon until

four years ago, at which time I moved into my present title.

Q. Now, Essentia Health. Can you tell us where that's located?

A. Yes. So at the time that this case was taking place, the organization was known as the Duluth Clinic. It grew at the -- subsequent to that to a merged organization of the Duluth Clinic and St. Mary's, at which point it became SMDC -- St. Mary's-Duluth Clinic -- and subsequent to that, it merged into an organization that spanned across northern Minnesota and northwestern Wisconsin and took the name Essentia Health.

Q. So you've been with this organization since 1991. Is that correct?

A. 1981.

Q. 1981. My mistake. 1981?

A. Correct.

Q. Okay. Briefly, what do you -- what do you do in your current work as Chief Informatics Officer?

A. Putting it briefly, I'm an ambassador that works to meld clinical operations and IS, or information services, in blending the electronic health record.

Q. Now, I'd like to turn back the clock a little further. You're -- can you briefly describe for us your education and training?

A. Yes. I -- I don't know how far back you want me to go, but I did my undergraduate degree work in Nebraska. I grew up in Nebraska and got a bachelor of arts degree at Hastings College in Hastings, Nebraska, and then went to medical school at the University of Nebraska College of Medicine, did my general surgery residency there, finishing in 1981 and then came directly up here, entering surgical practice directly out of residency.

Q. Are you a licensed physician?

A. Yes, I am.

Q. In what state?

A. In Minnesota.

Q. Are you board certified?

A. Yes, and have been continuously since 1981.

Q. What's your area of certification?

A. General surgery.

Q. Okay. So we're going to mark as Exhibit Number 1 a copy of your CV. Now, in the practice of general surgery, what other position -- did you hold any positions besides just general surgeon?

A. Well, I was on various committees, I acted as my surgical section chair, and then also as the

surgical division chair on and off for a number of years.

Q. And just looking at your CV, you're also a member of the American College of Surgeons. Is that right?

A. That's correct.

Q. You have a -- do you still have an academic appointment at the University of Minnesota School of Medicine?

A. Yes.

Q. Okay. All right. Now, changing subjects, Doctor, have you had an opportunity to review in preparation for today's work medical records of the care and treatment of Oswald Suoja?

A. Yes.

Q. And is it your understanding, then, that he was diagnosed with mesothelioma?

A. Yes.

MR. WATSON: This is Brian Watson. Let me just object at this moment. Owens-Illinois objects because plaintiff disclosed Dr. Wiig as a non-retained expert who would testify about the medical care and treatment that Dr. Wiig provided. Specifically, plaintiff disclosed Dr. Wiig to testify about his treatment as disclosed in the medical records and to

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opinions formed in the course of the treatment he provided. Therefore, Owens-Illinois objects to foundation and disclosure -- or non-disclosure -- of any testimony that Dr. Wiig may provide about medical records outside of his own treatment of Oswald Suoja.

MR. McCOY: Okay. So that objection is noted for the record.

MR. WATSON: And will you allow that to stand so I don't have to object throughout the deposition?

MR. McCOY: Yes. You can have a standing objection to that. Sure.

BY MR. McCOY:

Q. Now, Dr. Wiig, can you describe for us what role that you personally had in the care and treatment of Oswald Suoja?

A. Yes. I was asked to see Mr. Suoja after he was worked up for complaints referable to some indistinct abdominal complaints which initially brought him to his primary care team and then resulted in a referral to a gastroenterologist. Up to the point that I saw him, the workup included some lab work and imaging studies including ultrasound, barium enema, and CT scan, and those studies suggested that there were some indistinct abnormalities that may

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indicate -- may have indicated that there was the presence of indistinct tumor masses in his abdomen. The feeling on the part of the gastroenterologist was that further clarification could be obtained by a surgical exploration and, after colonoscopy failed to reveal any further clarification, he was referred to me.

At that point, I reviewed the results of the workups. I reviewed the x-rays with the radiologist, the CT scan specifically, and I discussed the -- the situation with Mr. Suoja and his wife, and we agreed that -- that in order to obtain further clarification of exactly what was going on with reference to his complaints, that we should entertain the possibility of a laparoscopy. After I discussed that procedure with he and his wife, they agreed to proceed ahead.

The procedure was performed, and at the time of the procedure, we discovered that there was a very extensive malignancy with tumor evidence basically throughout his abdominal cavity, encasing and studding, if you will, most all of his abdominal organs and the lining of his abdominal cavity on the inside of his abdominal wall. I performed multiple biopsies and also suctioned out somewhat more than a liter of abdominal fluid and sent all of those

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specimens for pathologic examination. So basically, the study which I -- the surgical procedure that I performed was basically a diagnostic study; not a therapeutic study or surgery.

He tolerated the procedure okay with some minor nausea and he needed a couple of days in the hospital to gain his strength back and to -- to get over his nausea.

And the final pathology result which I revealed to he and his wife did, in fact, confirm that -- with special stains that were performed by the pathology department, did confirm that all of the tissue specimens that I obtained were malignant and that they were -- they were indicating mesothelioma, peritoneal and abdominal mesothelioma.

MR. WATSON: Objection; form, foundation, narrative, nonresponsive, and lack of qualification.

Q. Doctor, I was going to ask you to describe the -- the history of Oswald Suoja's care and treatment. That was going to be my question. Based -- and I think you -- you've done -- done that so far, so I -- I -- I won't re-ask that question.

You are familiar with the records to be able to describe what other physicians that were involved

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in the care and treatment of Mr. Suoja recorded. Is that right?

A. Yes.

Q. And you were advised by these physicians and through the records during the time that you also were serving in the role of the -- of the surgeon as far as the care and treatment of Oswald Suoja. Is that right?

A. Yes.

MR. WATSON: Objection; form, foundation, vague, overbroad as to "the records."

A. Yes.

Q. All right. So continuing after the -- you advised -- well, first let me ask one question. When you say "abdominal cavity," what are you referring to? What part of the body? What organs?

A. The abdominal cavity is the space between the chest cavity and the pelvis that contains all of the extraabdominal organs, so all of the solid organs, such as liver, spleen, pancreas, kidneys, et cetera, and then all of the hollow viscous organs, such as the stomach, small intestine, and colon and bladder.

Q. And how was it that you were able to observe the tumor?

A. We used what's called a minimally invasive

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technique, so rather than having to make a large incision, we were able to visualize the -- these various tumor surfaces and organ surfaces with the use of a laparoscope. So basically, you -- an internal periscope, if you will, uses a camera and internal illumination. The abdominal cavity is inflated, somewhat like a balloon, if you will. The organs are floated apart by carbon dioxide, and this allows us to see the various surfaces, and then we're able to manipulate and do whatever work we need to do. Many current -- currently, many surgical procedures of various kinds are -- are commonly done using the laparoscope. This offered Mr. Suoja a -- a chance at having this step accomplished with the least amount of invasion into his body as possible.

Q. What characteristics did you observe through the laparoscope to know that this was a -- a cancerous or tumorous disease?

MR. WATSON: Objection; form, foundation, as to the ability to observe the cavity in order to diagnose --

A. Well, the -- obviously, any surgeon who has performed a number of laparoscopic procedures knows full well what normal organs internally look like, and when they appear distinctly abnormal with nodularity,

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abnormal growths, gray tissue that should not be there, encasements by gritty and granular kinds of gristle tissue and so on that normally should not be present in those locations, that is a strong indication of malignant growth in those locations, and Mr. Suoja's abdominal cavity demonstrated those growths over most -- as I -- as I indicated earlier, over most of the organ surfaces, both his bowel surfaces, his -- the surfaces of his lining of his abdomen, and even some of his solid organs.

Q. So what was the next step after you conveyed the -- the diagnosis to the Suojas, Mr. and Ms. Suoja, as far as care and treatment?

A. We asked -- we -- I wrote for a consult for a medical oncologist -- that's a medical cancer therapy treatment specialist -- to see him in consultation to offer whatever additional information might be necessary for them to make any further decisions about further treatments.

Q. Okay. Who was the oncologist?

A. Dr. Robert Dalton.

Q. He's at the same clinic, or was?

A. Yes.

Q. He's now retired?

A. Yes.

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Q. All right. So what -- what happened as a result of -- did the Suojas then have a consultation with Dr. Dalton?

A. Yes.

Q. And what was the outcome of that as far as further care and treatment?

MR. WATSON: Objection; form, foundation to this doctor's participation in that treatment.

A. At that point, it was recognized that no further treatment options could be realistically offered Mr. Suoja to achieve any meaningful outcomes, whether it be cure or long -- longevity, and so he was basically offered comfort care.

Q. Is that the same as palliative care?

A. Yes.

Q. Okay. And what did that involve for Mr. Suoja?

A. Well, initially, I was managing his postoperative discomfort and he was discharged to his home and he was given follow-up appointments with Dr. Dalton to initiate the palliative care formats, and -- after the postoperative period was over with.

Q. Okay. And so what -- what ensued as far as the palliative care stage?

MR. WATSON: Objection; form,

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foundation, vague, overbroad, lack of foundation.

A. Well, his condition worsened at home and he actually required readmission fairly soon, within a few weeks, and it was due to increased discomfort and probable bowel obstruction. So at that point, he was placed actually on hospice care, not palliative care, because it was felt, due to the degree of deterioration that he had undergone, that his life span was in fact more limited than anyone had appreciated, and so he was stabilized and controlled, got his pain under control and his vital signs under control in the hospital stay, and then he was discharged to home hospice.

Q. All right. So there was -- this was -- the laparoscopy procedure, was that done in the hospital?

A. That was done in the hospital in early to mid November, and the -- this hospital stay that I'm referring to was in early Ja -- to mid Ja -- December. Excuse me. Early to mid-December.

Q. The two hospital stays and then -- and then to hospice. Is that what happened?

A. That's correct.

Q. And in terms hospice care, do you have the records of some of the hospice care there?

A. Not -- not the home hospice, no.

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Q. Okay. What -- what further information do you have about hospice care period --
A. Just --
Q. -- either based on your recollection or your records?
A. None, really, that -- other than I saw a note in the chart that said they -- the primary care doctor was notified by home hospice that Mr. Suoja had passed away in late December and he was notified by the home hospice team.
Q. Okay. Let me turn to a couple of the specific records for a moment. First I'd like to start with the first one. That's got Suoja medical 288 in the lower right and it's dated 9/10/1996. Right?
A. That's correct.
Q. And this was a visit with one of the Duluth Clinic physicians. Is that right?
A. She's --
MR. WATSON: Objection; form, foundation, misstates the document.
A. She's a nurse practitioner under the direction of Dr. Slag, who is -- was Mr. Suoja's primary care endocrinologist.
Q. Okay. And I understand that Dr. Slag has a

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health condition that prevents him from testifying. Is that your understanding?
A. Yes.
MR. WATSON: Objection; form, foundation, relevance.
Q. Is that your understanding, Doctor?
A. Yes.
MR. WATSON: Objection.
Q. All right. So the nurse practitioner then -- that was my mistake -- and this is a Janet Cismoski who's prepared this document that's page number 288. Right?
A. Yes.
Q. Okay. And in here, she notes the sentence -- I'm going to read this. It's about halfway in that -- that first large paragraph: "Some pain in the right lower quadrant of his abdomen." Do you see that sentence?
A. Yes.
Q. Okay. Now, based on the work you did and the records of the care and treatment of Mr. Suoja, to what would you attribute that expression of pain that was in the -- in the record on 9/10/96?
MR. WATSON: Objection; form, foundation.

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A. Well, I -- you know, it's very difficult to say with any degree of certainty what that pain could be due to. Based on ultimately what I saw, it's certainly possible that it could have been due to the encasement of his bowel by the tumor because the bowel was well encased with tumor, but there are certainly plenty of things that can cause discomfort in the abdomen at any given time. So --
Q. Okay. Go ahead.
A. I don't think that with any degree of certainty I can say one way or the other what specifically was the cause. It is certainly very possible that it could have been caused by what I saw at the time of the exploration, but people have -- who have no tumor also have pain in the abdomen.
Q. Is there any other explanation that's likely from the medical history as to the cause of that pain in the abdomen?
MR. WATSON: Objection; form, foundation.
A. Well, you know, he had longstanding diabetes, and sometimes diabetes can cause bowel disruption or dysmotility, and -- and so dysmotility of the bowel can result in cramping discomfort in various locations in the abdomen. That's all sometimes very difficult

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to sort through. That was some of the initial difficulty in sorting out his over -- overall picture of symptoms, I think, but -- so I think that at the time that he presented at this point, I don't think it would point -- his some -- the complaint of some pain in the right lower quadrant wouldn't necessarily lead you definitively one direction or another.
Q. Okay. Those are the two possible directions that you see in his records would be either the growth -- growing tumor at that time or the diabetes?
A. Yes.
Q. Or I suppose the combination of both. Right?
A. Yes.
Q. Could be?
A. Yes.
Q. Okay. All right. So then going forward in the records, on the -- Page 286. I think that's the third page in the stack. There is a reference to the statement there in that first paragraph, "He has occasional pain in his middle abdomen, 'once in a while my gut hurts and certain foods give me a belly ache but overall, I'm not in any way in bad pain.' This usually occurs after meals." Is that basically a statement of the same -- same pain?
A. Yes.

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MR. WATSON: Objection; form, foundation.
Q. Okay. You can wait on your answers maybe just a moment to allow the objection to be stated, Doctor.
A. Okay.
Q. So -- and then continuing on Page 280, which is a couple pages after that, the 9/30/96 visit with Dr. Van Norstrand. Do you find that one?
A. Yes.
Q. Okay. Dr. Van Norstrand was in what capacity at this time with the clinic?
A. He was a gastroenterologist.
Q. All right. Again, there's mention there in that first long paragraph, about three or four sentences into it, it states that right upper quadrant pain just prior to having his bowel movement and that once he has finished the bowel movement, this usually resolves. The pain can also occur in the left lower quadrant and left upper quadrant at times; again usually resolves with bowel movements.
Would you characterize this as a continuation of that same type of pain that he originally came in with?
A. Yes.

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MR. WATSON: Same objection as to form and foundation, the "same type of pain."
A. Yes.
Q. Now, continuing on to maybe about ten more pages or so where it says Suoja Medical 278 in the lower right. Let me know when you find that page, Doctor.
A. I have it.
Q. Okay. And this is a 10/28/96 consult again with Dr. Van Norstrand. Is that right?
A. Yes.
Q. And this does -- this makes mention of the -- in that second full paragraph that the findings have been reviewed with -- with yourself and -- is that Dr. Aas?
A. It's pronounced "Oz." It's a Danish name.
Q. "Oz"? Okay. Dr. Aas and yourself. Right?
A. Correct.
Q. Okay. And this is -- it says you agree that a laparoscopic examination of the abdomen would be appropriate, which is -- that's what you already described for us. Right?
A. Yes.
Q. Okay. And then at the bottom, the third paragraph refers to the appointment being made with

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yourself to arrange the procedure. Right?
A. Yes.
Q. All right. So then October 31 of 1996, this is a -- and that's the next page, Suoja Medical 277. This is your first actual -- report of your first actual consult with Mr. Suoja. Is that right?
A. Yes.
Q. Okay. And did his wife always accompany him for these visits?
MR. WATSON: Objection; form, foundation, misstates the medical records.
A. Well, I don't know for sure if she came to all the others. I don't have any direct -- other than comments made in the record, but she came to this one for sure.
Q. Okay. And this is the visit where you've described that they agreed to go through with the laparoscopy procedure. Right?
MR. WATSON: Objection; form, foundation. Bob, can we stop leading the witness at some point?
MR. McCOY: Okay.
BY MR. McCOY:
Q. Doctor, I'll ask the question in another way. What -- what happened as a result of this visit?

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A. The laparoscopic procedure was scheduled after they agreed to proceed ahead.
Q. Okay. Then let's turn to page -- so -- Suoja Medical Number 1. That's about another five or six pages later there. Actually, go to Suoja Page 2. One and two look alike. Did you find that one? That's the surgical pathology report.
A. Yes.
Q. Okay. So Suoja Medical Page 2 is -- is what?
A. Is that a question?
Q. Yes.
A. This is a surgical pathology report, basically describing the specimens that I submitted from the -- the tissue specimens that I submitted. Describes the source from -- the location that I took them, and then follows on down describing the gross inspection, the macroscopic inspection, and then finally the microscopic examination of the -- of the -- microscopic inspection of all the tissue specimens, and included in the microscopic inspection is -- are a description of the special stains that were performed to help elucidate and identify characteristics of the tumor cells.
Q. So four different specimens were examined: A, B, C, D. Right?

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A. That's right, from four distinctly different areas of the abdomen.
Q. All right. And what were the findings on -- on these specimens?
A. Each one of the specimens demonstrated tissue cells that were consistent with epithelial mesothelioma.
Q. Suoja Medical Page 2 is also part of the surgical pathology report. Right?
A. That's correct.
Q. And the date on this report is -- looks like the specimen was received on November 11th of 1996. Right?
A. Yes.
Q. Okay. And the Suoja Medical Page 3, that's the diagnosis from the report. Right?
A. Yes.
Q. Okay. And what was the diagnosis?
A. The final diagnosis is signed out as peritoneal biopsies, all four specimens labeled A through D are epithelial mesothelioma.
Q. And what does that term "peritoneal" mean?
A. It means that -- that it was a surface -- they were surface biopsies. They weren't deep, intra-tissue biopsies within, for instance, the -- the

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deep, internal portions of a solid organ, like a deep internal liver biopsy or something. They were surface biopsies.
Q. And who was the pathologist that prepared this report?
A. Dr. Bruce Henke. He's also retired.
Q. Okay. The next page is Suoja Medical 242 and 243 together. Right?
A. Yes.
Q. Okay. And what is this document?
A. This is my dictated and transcribed operative note.
Q. And this is what you've already described for us as far as the -- the procedure that you performed. Right?
A. That's correct.
Q. Okay. I want to turn to page Suoja -- Suoja Medical Page 247 and continuing through Page 250.
A. Okay.
Q. These are handwritten. What -- what are these called?
A. These are --
Q. Who prepares these?
A. These are handwritten progress notes by physicians who round on the patient during the

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hospital stay. Mostly readable.
(Laughter.)
Q. Right. Okay. Well, you're in the age of informatics, the new age where everything is typed right away. But okay.
Continuing on, page -- Suoja Medical 234. I think there's another page of notes and then Suoja Medical 234. Do you find that one?
A. Yes.
Q. Okay. And what is Suoja Medical 234?
A. This is my hospital discharge summary from the stay -- the two-day hospital stay for his laparoscopic procedure.
Q. And again, this is -- this is what you already described for us. Right?
A. Yes.
Q. Okay. I'm going to turn next to document that begins at page -- Suoja Medical 124, which is the next page.
A. M-hm.
Q. Can you -- through Page 126, and tell us briefly what this is.
A. This is a history and physical examination from an admission just one month later for nausea, vomiting, distension, and likely bowel obstruction.

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Q. A copy of this was routed to you. Correct?
A. I don't necessarily see evidence of that on this.
Q. I'm just looking where it says "physician" up at the top.
A. Oh, yes. There it is. I'm sorry. Yes. I do see that now, yes.
Q. I want to just -- and this -- this report is one that was actually prepared by -- looks like Dr. Eckman.
A. Yes. He -- he was --
Q. Right?
A. -- covering call for Dr. Slag on a -- for -- at a night -- for nighttime call or weekend call. One of the two. I don't know which day that -- of the week this was, but....
Q. So this is -- this reflects another hospital admission. Is that right?
A. That's correct.
Q. It says -- I want to go to the last page, the Page 126 at the bottom. And there, it states, "Plan: He needs palliative care and has already been started on morphine." Do you see that?
A. Yes.
Q. Okay. Now, in terms of the care and

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treatment that Mr. Suoja got, what -- what role does morphine play?
A. Well, it's an opioid, so it's a pain relief medication.
Q. And what is the reason why he would be given pain relief at this time?
A. Well, if he has refractory pain or severe discomfort, then -- then the physicians caring for him provide whatever pain relief in the -- in the degree or dose that's necessary in order to try and relieve his pain.
Q. The next page I believe is Suoja Medical 119.
A. Yes.
Q. And looking there at the physical examination, it reflects he is uncomfortable with abdominal pain?
A. Yeah. So -- yeah.
Q. So at this point in time, after you have observed that, the tumor and the diagnosis has been made, what -- what is the -- what is your judgment in terms of what would be the cause of this kind of pain that would require morphine?
A. Well, I think in -- at -- in this time frame and with the diagnosis now having been established, it has to be assumed that it's secondary to the tumor,

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and this note on 119 is an emergency room admit note by an emergency room physician, Dr. Daniel Campbell, so it's related to the admission history and physical on the previous page by Dr. Eckman, because it had to be Dr. Campbell's impression from the emergency room that Mr. Suoja was ill enough that he needed to be admitted. That's -- that's how these two documents are related.
Q. In the past medical history on 119, it shows -- states that patient was diagnosed 11/11/96 with abdominal carcinomatosis secondary to diffuse abdominal mesothelioma?
A. Yes.
Q. That's -- that's essentially the findings you've already described. Right?
MR. WATSON: Objection; form, foundation, vague, overbroad.
A. Yes.
Q. I'll -- I'll change the question, Doctor.
A. Okay.
Q. It states in there, "The patient was diagnosed 11/11/96 with abdominal carcinomatosis secondary to profuse abdominal mesothelioma." What does that statement mean with reference to the care and treatment of Mr. Suoja?

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MR. WATSON: Objection; form, foundation, vague, overbroad as to this doctor's treatment.
A. Well, it's a description of -- of the findings that occurred during the -- during the diagnostic procedure that I performed and it frames the reference for -- it -- it sets a frame of reference for, I think, the -- the treatment going forward for his current level of complaint, for this hos -- emergency room visit.
Q. And the next sentence says, "The patient was not a surgical candidate because of the diffuse nature of the peritoneal involvement." What -- what does that -- what does that mean in the context of Mr. Suoja's care and treatment?
A. Because of the extensive involvement -- basically covering every surface in the peritoneal cavity -- there simply is no physical or mechanical ability to remove the tumor. It basically would remove -- mean removing every single abdominal organ from his body, and that's in -- that is incompatible with life.
Q. Is -- is that judgment about whether there can be surgery to correct the tumor something that you're -- you were involved with?

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A. Yes.
Q. Okay. And the next statement says, "It was felt necessary to pursue a symptomatic and palliative approach to the problem." And again, what's that mean in reference to -- or in the context of Mr. Suoja's care and treatment?
A. Once it had been established that there was no reasonable approach to a therapeutic treatment option, then I think a palliative or comfort-care approach was the treatment option that we had to pursue, or that Dr. Dalton and Dr. Slag had to pursue with Mr. Suoja, so that was the discussions that had been held.
Q. Okay. And -- and this care and treatment that Mr. Suoja received, this -- this was all through, at this time, the Duluth Clinic. Right?
A. Yes.
Q. Okay. And this -- is it fair to say this -- this care and treatment, these records are a collaborative effort where the different physicians, including yourself, shared information with each other?
MR. WATSON: Objection; form, foundation, overbroad as to what is meant by "this treatment" and "these records."

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Q. You can answer, Doctor.
A. Yes.
Q. Can you elaborate briefly on -- on how this works, where a patient has multiple doctors in this type of scenario with a -- with a tumor, how that -- how that sharing of information occurs?
A. Well, for any patient who has multiple physicians or multiple specialty services taking care of them, the sharing of information between those multiple clinicians and multiple services takes care [sic] on many different levels. It can take place on a conversational level; it can take care -- it can take place on merely reading the notes in the inpatient chart; it -- in the era of the electronic medical record, it can take place by reading copies of the electronic medical record; and, as you've seen examples in this chart, we route -- we routed copies of the paper forms back and forth to each other in order to maintain an information passage and sharing; and then finally, I think that the -- in some sense, when we have formal conferences, such as tumor conferences or other shared service conferences around specialty topics, information is shared for the purposes of multimodality benefits to patients. So there are many different formats that these sharings

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can take place in.
Q. Okay. And this kind of sharing, then, was followed in the case of the care and treatment of Mr. Suoja. Right?
A. Yes.
Q. Finally, we -- we come to the last note I want to talk about, handwritten note. This is Suoja Page 176. It's about another eight, ten pages later.
A. Yes.
Q. And down at the bottom right, it states this -- these are -- by the way, what -- what kind of a document is this? It's titled progress notes.
A. Yes. It's titled nursing progress note, so this is a nursing note from hospice, the inpatient hospice unit, so this -- this is a note from -- after the patient was transferred from a different unit in the hospital to hospice unit, and this is the nursing intake note after Mr. Suoja was transferred to hospice unit, the inpatient hospice unit.
Q. Okay. This -- at the top, looks like it's dated 12/15 of 19 -- must be 1996. Right?
A. Yes.
Q. Okay. And down at the bottom right, it says, "Pain all over." Do you see that?
A. Yes.

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Q. Okay. Now, based on the care and treatment of Mr. Suoja, what would you attribute this statement of "pain all over" to?
A. Well, I'm having, again, to -- to make an assessment that as he was going through the last stages of his malignant process, that the malignancy was the source of -- of the -- most of the end-stage symptoms that he was beginning to demonstrate.
Q. I'd like to go back briefly to November 13th, 1996. Is this a report you created?
MR. WATSON: Is there a number associated with this?
A. I have to ask the same question.
Q. Yeah. It's Suoja -- is this the right one here? Actually, I think it's November 11th, 1996. It's my mistake. No. I'm sorry. I'm sorry. I'm correcting myself again. It's Suoja Medical 234. Little bit --
A. My -- my discharge summary?
Q. Yeah. Discharge summary. And --
A. Yes.
Q. -- what -- what was the discharge date from this hospitalization, the first one?
A. November 13th.
Q. Okay. So at -- what I wanted to do is to

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ask -- ask you, you know, based on your care and treatment of -- of Mr. Suoja and -- and the findings of the -- from the surgical patholo -- surgical pathologist, what -- what judgment do you have as to what would have caused this mesothelioma in Mr. Suoja?
MR. WATSON: Objection; form, foundation, qualification, lack of qualification, outside the scope.
A. Well, based on my reading and the -- Mr. Suoja's job history, I'd have to presume that it was his exposure remotely to asbestos.
Q. And this -- you made a statement down here in your November 13th discharge report which says, "This may well be related to his remote lengthy history of asbestos exposure." Right?
A. Let's see.
Q. I'm looking at the clinical course.
A. Yes.
Q. Okay. I'd like to go to Suoja Medical 113. I think I'm almost near the end here. That's about five or six pages from the end. It says the discharge summary, date discharged, December 24th.
A. Yes.
Q. Did you find that one?
A. Yes.

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Q. All right. So this makes reference to an admission via the emergency room with increasing abdominal pain and evidence of bowel obstruction in the emergency room. What is bowel obstruction?

A. Bowel obstruction is basically akin to -- analogous to thinking of kinking off a garden hose to run out and change the sprinkler, so some process or another blocks the bowel from being able to propel the normal food material or even just liquid material through it, and so what happens is that the normal muscular activity of the bowel to propel food comes down to the point of blockage and then hits -- hits the kink, or the obstruction, and that food or liquid material begins to back up and -- and distend and get inflated to a degree more than it's accustomed to, and that results in bloating and cramping discomfort.

Q. Was the emergency room able to correct this situation in Mr. Suoja?

A. Well, they -- they put down what's called a nasogastric tube, so that's a tube that goes through the nose and then down into the stomach. That helps suction food so that -- or suction liquid material from the stomach so that at least no further liquid will proceed down the bowel, and it also keeps the patient from feeling the unending need to try and

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vomit. So it -- it tries to at least reduce the patient's degree of discomfort and his degree of pain -- well, his degree of pain and the degree of discomfort from the sense of need to -- needing to vomit.

Q. At this point in time of the -- after the diagnosis of mesothelioma and the -- and the course that the disease took, to what would you attribute that bowel obstruction?

A. Oh, I think, based on what my findings were at the time of the laparoscopy, the bowel obstruction would have to be felt to be due to the tumor progression.

Q. All right. I wanted to ask one other question; then I think we're about out of the -- out of the woods here, Doctor.

As far as Mr. Suoja's diabetes condition is concerned, do you have an opinion one way or the other whether that would have shortened his life?

A. No.

Q. All right. Finally, I guess the last question is in terms of the care and treatment of Mr. Suoja, was there a -- a time where he was anything other than a cooperative patient?

A. Not that I witnessed.

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MR. McCOY: That's all the questions I have. Thank you.

EXAMINATION

BY MR. WATSON:

Q. Doctor, it's Brian Watson. Are you good to continue or do you want to take a -- a short break?

A. No, I'm good.

Q. We -- we at least met telephonically for the first time today. Is that right?

A. Yes.

Q. Did you ever meet Gary Suoja?

A. Not to my reso -- not to my recollection.

Q. Did you ever meet Ken Suoja?

A. Not to my reso -- recollection.

Q. Did you ever meet Sue Merwin?

A. Not to my recollection.

Q. To your recollection, do you remember seeing Gary Suoja, Ken Suoja, or Sue Merwin at any visits?

A. You know, I -- I would not -- I don't remember that. I -- I certainly -- I can remember because I documented talking to he and his wife, but I don't remember the surgical visits or the days in the pa -- you know, at the hospital. I don't remember if they were by or not. I -- I simply can't remember that.

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Q. When did Mr. Suoja pass?

A. He passed on -- in late December.

Q. When were you first contacted about this lawsuit?

A. I was first contacted about this in late October of this year.

Q. Who contacted you?

A. I got a packet of information from Mr. McCoy.

Q. What was the packet of information?

A. It was a letter and it was a -- a copy of the records.

Q. Do you still have the -- the letter and copy of the records?

A. Yes.

Q. What did the letter say?

A. Do you want me to read it?

Q. Oh. You have it here today?

A. Yes.

MR. WATSON: Could we mark as Exhibit 3 the -- the letter?

(Dr. Wiig Exhibit 3 was marked for identification.)

THE REPORTER: Exhibit 3 has been marked.

BY WATSON:

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Q. Doctor, what's Exhibit 3?
A. What's Exhibit 3?
Q. Yeah. What is that document?
A. It's a letter.
Q. And since I'm not there in person, I'm sorry that this is a bit awkward, but what does the -- the letter say?
A. Do you want me to read it?
Q. Could you, please, Doctor?
A. Says, "Dear Dr. Wiig: My law firm represents your former patient Oswald Suoja, in a lawsuit regarding Mr. Suoja's asbestos exposure and mesothelioma. The lawsuit is against the manufacturers and suppliers of asbestos products. The trial begins on November 30th, 2015, in Madison, WI. We would like to set up a brief phone call or meeting with you to discuss Mr. Suoja's care and treatment within the next 7 days. A medical authorization is enclosed. A copy of the records received from your office are also enclosed. My firm will pay your normal charges for lawsuit consulting.
"Thank you for your valuable time.
"Yours truly," so on.
MR. McCOY: Brian, for the record, that's in the e-mail that I sent you -- that I sent to

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Ed a few days before today, Ed Casmere, your co-counsel.
Q. Doctor, were the records that were marked as Exhibit 2 the same records that were sent to you under this October letter?
A. Yes, by and large. There were a few additional ones in Exhibit 2 that weren't in the original packet.
Q. Do you still have the original packet?
A. Yes.
Q. Doctor, I think you know where I'm going with this, but could -- could we mark as Exhibit 4 a copy of the records that were received?
(Wiig Exhibit 4 was marked for identification.)
THE REPORTER: Exhibit 4 has been marked.
BY MR. WATSON:
Q. And -- and just so we're sure, Doctor, Exhibit 4 is a copy of the records that were sent to you from Robert McCoy on October 2015 with the letter that was marked as Exhibit 3?
A. That's correct.
Q. In the -- in the letter, it talks about a brief phone call. Did you have a brief phone call?

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A. Yes.
Q. When was the brief phone call?
A. Oh, lord. (Pause.) I'm looking at my calendar. (Pause.) Well.... (Pause.) It was on November 11th.
Q. Did you have any other conversations with the plaintiff's counsel other than November 11th, Doctor?
A. No.
Q. Did you receive any written communication other than the -- the letter that's from October 2015 -- 2015 marked as Exhibit 3?
A. Just the packet that I've been working off of today.
Q. And you received that for the first time today?
A. Yes.
MR. McCOY: Brian, for the record, the -- the e-mail I sent to Ed Casmere, again, your -- your co-counsel, has both the sets of records. That -- one is the Exhibit 2 and one is the Exhibit 4, and -- and -- both of them, along with the cover letter to Dr. Wiig, so you -- you guys have had it since that was sent on November 20th, all of the information that Dr. Wiig has gotten from our office. Go ahead.

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BY MR. WATSON:
Q. Doctor, the letter also says you'll pay for normal charges of lawsuit consulting. Have you been paid for today?
A. I don't even know.
Q. Have yet to be paid for today?
A. I don't even know. It goes through a -- a corporate office here.
Q. Got it. So you haven't been asked or received any individual compensation for your consulting and testimony here today, have you?
A. No. I have a form that I fill out corporately that I'm -- that I have in front of me that I would fill out for time committed to this, but that's it.
Q. Doctor, when was the last time that you looked at the records that were sent from Mr. McCoy in October?
A. Oh, I suppose earlier this morning.
Q. And before this morning and the -- and the records that were received in October 2015, when was the last time that you saw any records related to Mr. Suoja?
A. Well, I'd have to say it was 1996.
Q. What did Mr. Suoja look like in 1996?

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A. Do you want an accurate description?
Q. Yes, please.
A. I can't give it to you.
Q. What did Delores Suoja look like back in 1996?
A. I can't give that to you either.
Q. Were you Mr. Suoja's oncologist?
A. No.
Q. Were you Mr. Suoja's primary care physician?
A. No.
Q. Were you the pathologist for Mr. Suoja?
A. No.
Q. Were you the radiologist for Mr. Suoja?
A. Nope.
Q. Were you the doctor that performed the laparoscopy for Mr. Suoja?
A. Yes.
Q. And you performed that in your role as a --
A. General surgeon.
Q. General surgeon at which hospital?
A. St. Mary's. St. Mary's Medical Center.
Q. Besides -- besides the role -- the treatment and the surgery, had you....
A. Was there something -- was there a question there?

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Q. Sure. Before the surgery and the treatment of Mr. Suoja, had you ever seen him before?
A. No.
Q. What was the first date that you ever saw Mr. Suoja?
A. The date of my original consult, which was October 31st, 1996.
Q. Do you have any records of Mr. Suoja's lifestyle and medical treatment besides the ones that are marked as Exhibit 2 and the ones that are marked as Exhibit 4?
A. No.
Q. Did you select the documents that are marked as Exhibit 2 and Exhibit 4 for today?
A. No.
Q. Who did?
A. Mr. McCoy, I suspect.
Q. Do you have the complete records for Mr. Suoja for your testimony today?
A. I have the complete records pursuant to my intervention -- my -- my intervention with him, yes.
Q. You feel you have the complete records for that in your testimony today?
A. Related to this episode of care, yes.
Q. I'm going to step through the records then a little bit, but are you an expert in pathology?

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A. No.
Q. Are you an expert in radiology?
A. No.
Q. Are you an expert in epidemiology?
A. No.
Q. Are you an expert in oncology?
A. No.
Q. Are you an expert in asbestos-related diseases?
A. No.
Q. Do you keep current on medical or scientific literature on asbestos-related diseases?
A. No.
Q. Do you recognize that there are doctors and experts in asbestos-related diseases?
A. Yes.
Q. Would you obtain their books if you needed answers about asbestos-related diseases?
A. Yes.
Q. Would you defer to the opinions of experts in asbestos-related diseases for this case?
A. Yes.
Q. Doctor, what percentage of peritoneal mesotheliomas are not asbestos-related?

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A. I can't answer that to a definitive degree. I do know that peritoneal mesotheliomas are a very small fraction of mesotheliomas as a whole and that even though it's still rare, that a goodly number of peritoneal mesotheliomas are related to asbestos exposure and that no one has figured out how the asbestos transmigrates from the usual routes of airborne asbestos exposure to the peritoneal cavity.
Q. Do you have an opinion about how asbestos is ingested and then gets to the peritoneal --
A. No. That's just what I was talking about: people have surmised about diaphragmatic transmigration, people have talked about ingestion through water sources and mucosal transmigration through the bowel -- or through the bowel wall, but to this date, to my knowledge, no one has actually definitively proven what the -- what the actual route of -- of that contamination is.
Q. Doctor, do you have an opinion about the dose of asbestos exposure required to attribute cancer to asbestos?
A. No.
Q. Do you have any information about the dose of exposure that Mr. Suoja experienced?
A. Nope.

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Q. Do you have any information about the dose of exposure that Mr. Suoja experienced from any particular product?
A. Nope.
Q. Are you aware of the different fiber types of asbestos?
A. Vaguely.
Q. What are you aware of?
A. Short and long. That's about as far as it goes.
Q. Are you aware that there's different potency related with short and long asbestos fibers?
A. Yes, vaguely, but that's -- I -- I can't give you any further information than that.
Q. Okay. Did you evaluate the pathology from Mr. Suoja?
A. Myself? In terms of --
Q. Correct.
A. -- looking at the slides?
Q. Yes.
A. I didn't actually look at the slides myself. My evaluation consisted of personally discussing it with Dr. Henke, the pathologist, and conferring with him in person.
Q. If I understand it right, you -- you sent the

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pathology to Dr. Henke?
A. That's correct.
Q. And Dr. Henke reviewed the pathology and performed staining in order to come to a diagnosis?
A. Yes. Our -- because of the proximity of -- of our hospital facility to the intense mining operations in northern Minnesota, we have a pretty intense biopsy and screening program up here with our pulmonology department, and so our pathology department does a lot of the reference lab reading for those programs, and so they -- they've developed a lot of the -- or they maintain a very high degree of expertise in reading these slides and maintaining the special stains necessary for reading those.
Q. And you referenced the mining up in -- in Minnesota. Are there individuals that are exposed to tailings that develop cancer?
A. Well, again, as you've already pointed out so succinctly, I'm not an expert in all of that, but the screening programs have -- are trying to maintain close observation on all those miners, yes.
Q. Yeah. And there are individuals at the hospital that do that screening. Is that right?
A. That's my understanding.
Q. And not to be condescending at all, Doctor --

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I know you've gone through a terrific amount of training -- but those are others -- those are doctors other than you.
A. That --
Q. Is that fair to say?
A. That's correct.
Q. Are you aware of the diagnostic criteria for mesothelioma?
A. No.
Q. Are you familiar with the literature about other causes than asbestos for mesothelioma?
A. Nope.
Q. Are you familiar with the literature about radiation causing mesothelioma?
A. No.
Q. Are you familiar with the literature about SV40 vaccine causing mesothelioma?
A. No.
Q. Are you familiar with genetic or BAP1 mutations causing mesothelioma?
A. No.
Q. What percentage of mesotheliomas are idiopathic, Doctor?
A. I don't know that.
Q. What percentage of the general population in

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the United States die of cancer each year?
A. I can't give you that exact statistic.
Q. Would you agree that genetics plays a role in who develops cancer and who does not?
A. Yes, it can. Doesn't always, but it can.
Q. Do you agree that there are people that are exposed to asbestos that never develop mesothelioma?
A. Yes, I think that's a fair statement.
Q. Do you agree that everyone living in modern areas have asbestos fibers in their lungs?
A. Everyone? Say that again.
Q. Do you agree that everyone living in modern urban areas have asbestos fibers in their lungs?
A. I'm not sure I agree with that, but that's a matter of your opinion to mine.
Q. What percentage of people in modern areas have asbestos fiber in their lungs?
A. That I couldn't tell you.
Q. Do you agree that mesothelioma is a dose-related disease?
A. Yeah, I think that's probably true.
Q. And what do you mean by a dose relationship?
A. Higher the exposure, the more likely, I suspect.
Q. Was there any part of your treatment of

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Mr. Suoja that required you to determine the cause of his mesothelioma?
A. No.
Q. Can you identify which fibers that Mr. Suoja ingested actually caused his mesothelioma?
A. No.
Q. Do you agree that mesothelioma is a diff -- difficult diagnosis to make?
A. Yes.
Q. Do you have the qualifications to make that diagnosis?
A. I did have.
MR. McCOY: Let me -- Doctor, I have an objection to that question to form and foundation. You can go ahead and answer.
A. I did have.
Q. Could you explain what you mean by that? Did you have qualifications?
A. Well, I don't have surgical privileges at the hospital anymore. Because of the length of time that I've been involved in healthcare administration, I don't actively operate anymore and haven't for four years, so that's what I mean.
Q. So if I understand your testimony, you believe that you have the qualifications to look at

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pathology and make a determination of -- of mesothelioma diagnosis?
A. No. That's not how I took your question.
Q. Oh. Okay. I'm sorry. Let me back up. You agree that mesothelioma is a difficult diagnosis to make. Right?
A. Clinically or pathologically?
Q. Pathologically.
A. I can't comment on that. I -- I can comment on clinically.
Q. Well, do you need a pathologic finding of mesothelioma in order to diagnose mesothelioma clinically?
A. No.
Q. You can diagnose mesothelioma without a pathological determination?
A. No. I think you're getting off the track here, at least from my perspective. Mesothelioma, from my perspective as a surgical clinician, is hard to diagnose clinically. That's the statement that I'll make. I can't go beyond that.
Q. In -- in order to diagnose mesothelioma as a clinical surgeon, would you need a pathological finding?
A. Yes.

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Q. Doctor, do you have the qualifications to make a pathological finding of mesothelioma?
A. No.
Q. In other words, histochemical staining is required by somebody else to make a diagnosis of mesothelioma?
A. Yes.
Q. Doctor, do you agree that cancers are monoclonal?
A. I'm not sure that's -- it can be pure -- as purely stated as that. I --
Q. Do you believe that?
A. I just -- it's too complex.
Q. Do you believe that cancers begin in a single cell?
A. Well, again, if you believe in a theory that says one cell mutates and isn't surveyed immunologically and then divides to two and then to four and then to eight, then I guess you'd say it's monoclonal, but -- so they can be monoclonal. I guess that's --
Q. What's your opinion, Doctor, of whether they're monoclonal?
A. I guess you could say it's monoclonal.
Q. How many mutations are required in order for

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a cancer to control -- or to grow uncontrollably?
A. Oh, millions upon millions.
Q. In other words, it -- it takes a series of and millions of mutations for cells to actually develop into an uncontrolled cancer. Is that fair, Doctor?
A. Yes.
Q. Would you agree that there are many mutations that occur within people that don't develop into cancer?
A. Yes.
Q. If an individual is exposed to asbestos and asbestos causes a mutation in the cell, is it possible that the exposure that that person sustained doesn't cause cancer?
A. Yes.
Q. In other words, each exposure we have isn't a cause of cancer when we're exposed to mesothelioma -- or to asbestos, is it?
A. Well, whatever the stimuli or exposure is, no matter what type you're talking about, it has the potential for resulting in a cancer-causing mutation or -- or not.
Q. And there are exposures that result in cancer-causing mutations that don't actually develop

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into uncontrolled growth. Is that fair, Doctor?
A. Yes.
Q. We're exposed to a lot of cancer-causing agents, all of us, that don't develop into cancer. Is that right?
A. Yes.
Q. For example, we're all exposed to UV light which can damage our skin cells, but not everyone develops skin cancer?
A. Correct.
Q. There are individuals that are cigarette smokers which damage their lung cells, but not everyone who smokes or is exposed to smoke develops lung cancer. Is that true?
A. That's true, but don't take your chances.
Q. And there is exposure to mesothelial cells by asbestos that doesn't lead to mesothelioma cancer. Is that true?
A. Yes, but I'd say the same thing: do you want to drink the water for ten years?
Q. I'm just getting at, Doctor, the difference between causation and -- and -- and risk, and if I hear you right, you're saying better to keep exposures to cancer-causing agents lower, but not necessarily will each of those exposures cause cancer?

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A. Correct.
Q. For example, each exposure to asbestos doesn't cause mesothelioma.
A. For example? Yes.
Q. Right. And your cumulative exposure to asbestos doesn't cause mesothelioma?
A. That's too -- that's too all-encompassing a statement. It may not cause mesothelioma.
Q. Well, there are part -- there are some exposures that are part of your cumulative exposure to asbestos that don't cause mesothelioma. Is that true?
A. Yeah.
Q. So the total cumulative exposure that an individual has isn't the cause of their mesothelioma. Right?
A. That's fair.
Q. There are particular exposures and particular fibers that create enough mutations that result in uncontrolled growth and a mesothelioma cancer. Is that right?
A. That's fair.
Q. Doctor, I want to turn to -- well, let me ask you: would you defer the causation opinion of Mr. Suoja's mesothelioma to the experts in asbestos-related diseases and mesothelioma?

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A. Yes.
Q. I want to turn the -- to the medical records. I hope you have some of these, but if not, Doctor, just let me know that Mr. McCoy didn't provide them in your packet.
Doctor, on the records that you have, do you have Suoja Medical 128, which is a handwritten clinical note?
A. Is it in the packet from today? Yes. (Pause.) I have 129. I don't see 128. (Pause.) No. I don't have it.
Q. Okay. So I apologize for asking this question. It's potentially unfair to you, Doctor, but is it true that Mr. McCoy didn't provide you with medical record 128?
A. Correct.
Q. Do you have medical record 129?
A. Yes.
Q. Do you see on December 17th, 1996, a handwritten note?
A. Well, I see a couple of them. Oh.
Q. Under December 17th, 1996, do you see a handwritten note by --
A. Dr. Slag.
Q. Dr. Slag?

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A. Yes.
Q. And what does Dr. Slag say in the fourth line?
A. "He denies any pain now."
Q. And who do you attribute the "he" to?
A. I presume he's talking about the patient, Mr. Suoja.
Q. Do you have Suoja Medical 130?
A. Yes.
Q. Do you see an entry that's handwritten at the bottom of Suoja 130?
A. Yes.
Q. Whose entry is that?
A. That's a social service note.
Q. And who's -- who's the social service note by?
A. It looks like it's a master of social work, Gaye or Faye Held.
Q. And -- and generally, Doctor, so we understand, what -- what's a social service note?
A. It's a social worker who gets involved. Maybe it's Joyce. She writes a note at the top, too, on the -- on the previous day. So maybe -- so they get involved particularly with patients who have issues around needs for, for instance, services at

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home, support services or medical device services at home, things like that. And in this case, as Mr. Suoja was -- and his wife were facing the need for home hospice, they were -- they would definitely be needing the services of a social worker at home to help coordinate that.

Q. And the hospital has social service providers on staff to provide those needs?

A. Yes.

Q. What does the note on -- if you can read it, Doctor -- 12/18/1996, bottom of 130, say?

A. Met with Delores and son-in-law. Oh. Son and daughter-in-law. They would like patient to remain inpatient hospice. Son and daughter-in-law feel Delores is not able to provide care for patient at home. Will follow.

Q. Who was the son and daughter-in-law?

A. I don't know that. At this point, I wasn't actually directly involved in Mr. Suoja's care. This was the --

Q. Do you --

A. -- hospitalization subsequent to the surgical procedure, so....

Q. Do you ever remember meeting a son during any of the visits?

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A. Well, you already asked that, and no, I -- I don't remember that, but again, you know, during rounding and during all periods of the day when a family may visit, I -- I wasn't at the bedside, you know, 12 hours a day, so they could have been there and I wouldn't know it.

Q. Did -- did you ever talk with any son or daughter of Oswald Suoja about his surgery?

A. Well, I don't recall that, but then I don't recall talking to the wife separate from the husband either. It was 19 years ago.

Q. Would you have made a note as part of your practice if you had spoken with a son or a daughter --

A. Not --

Q. -- as part of a consult?

A. Not unless it involved the transmission of very salient or descriptive information.

Q. Do you have any notes in your records that show the transmission of such information --

A. Not that I --

Q. -- to you from any son or daughters of Oswald Suoja?

A. Not that I'm aware of, no.

Q. And of the records that Mr. McCoy provided and we've gone through today, you -- you didn't see any of those references, did you?

A. No.

Q. Do you have Suoja Medical 131 in front of you?

A. Yes.

Q. And, Doctor, if you need to take a break, I -- I understand; I just want to make sure that there is a complete review of the records since Mr. McCoy sent you some of them and went through some of them.

But on Suoja Medical 131, do you see an entry that's dated December 19th, 1996?

A. Yes.

Q. Who's the entry written by?

A. Again, Dr. Slag, the patient's endocrinologist and usual care gi -- care provider.

Q. What's an endocrinologist?

A. A specialist in internal medicine that focuses on care of patients with endocrine diseases, so things like diabetes, thyroid, pancreatic issues, and -- and so on. Adrenal issues.

Q. Would Dr. Slag have been a doctor responsible for the treatment of Mr. Suoja's diabetes?

A. Yes.

Q. Are you familiar with Dr. Slag's handwriting?

A. Yes.

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Q. Is it possible to -- to read for me the statement by Dr. Slag that is -- begins -- or appears to begin with a D?

A. So which line?

Q. Seven lines down.

A. "Discussed his wishes, home versus nursing home, and he had no preference. He thought his wife could care for him. I spoke with her yesterday and she was willing to consider having him at home but didn't see why he couldn't stay here as long as was needed until death occurred.

"Assessment: Diabetes, bowel obstruction, abdominal mesothelioma.

"Plan: Continue with current therapy, arrange home care versus nursing home."

Q. And why would Dr. Slag be having this consult with Delores as opposed to another doctor at the hospital?

A. Oh, well, at that point, there weren't necessarily very formal -- you know, 19 years ago, there weren't necessarily very formal delineations of palliative and hospice physician lines, and so oftentimes primary care providers took on that role, using the hospice care agency's staff to -- to help with that process, but they would continue the

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physician role themselves.
Q. How many total doctors were there in the hospital at this time in 1996?
A. Oh, I'm going to say probably between 175 and 250.
Q. In 1996, what did the hospital go by?
A. St. Mary's Medical Center, and the clinic practice was the Duluth Clinic.
Q. Do you have the Suoja Medical 132, Doctor?
A. I do.
Q. And at the top of Suoja Medical 132, does it appear like it's another social service entry?
A. Yes.
Q. Do you recognize the signature or the handwriting?
A. It looks like Alyce Heid [sic].
Q. What -- what role did Alyce Heid play at the hospital?
A. Well, she must have been a social worker at the time, so I --
Q. And you talked about --
A. She doesn't give her actual credentials at the end of her note, but....
Q. Okay. And you talked about the hospital's provision of social service before. Right, Doctor?

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A. Yes.
Q. I won't make you discuss that again, but could you at least read for us the entry on December 19th, 1996, that Ms. Heid provided?
A. Social service met with Delores and J. McDowell, RN, to discuss plans. Delores would like to take patient home and it has been -- it has been complicated because Delores son Darrold and Marcia, daughter-in-law, have been angry about need to discharge -- to do discharge planning. Patient and spouse have a history of conflict. Delores thought patient could stay here to die. Family conference scheduled for 1300 on 12/20. Delores, Darrold, Marcia, and patient's sister, Jan McNa -- McNewell [sic], RN, and C. Hendrickson, RN, and home care will be -- will -- will participate in that home care -- or that family conference on Monday. Maybe home -- and then may be home on Monday.
Q. Who was McDowell, RN?
A. She -- both of those nurses mentioned must be RNs on the -- on hospice floor.
Q. And Hendrickson? Who is Hendrickson?
A. She is again an RN.
Q. And then it says --
A. Cindy Hendrickson.

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Q. And it says MSW. I take that to mean master of social work?
A. Yeah. And so another social worker will take part in the discussion in that care conference.
Q. And, Doctor, you don't have -- looking back through my notes here, but you don't have Suoja Medical 128 that --
A. That's correct.
Q. -- that talks about that kids are distant. Is that true?
A. No, I don't have that.
Q. And you don't have the entry that says the -- Delores has contacted his union and will need records for lawyers, do you?
A. Nope.
Q. Doctor, did you take a history at any point or see a history at any point of Mr. Suoja?
A. Only as it exists in the chart now, as it's evident in the records.
Q. Okay. (Pause.) Do you have the November 5, 1996 encounter record with Martins, RN, which is the endocrinologist, or under the endocrinology department?
A. November 5th?
Q. November 5th. I have -- I have one that's

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marked as 50 -- Medical 54, Doctor.
A. Well, what I have here is Suoja Medical 237 and it's under -- it's Janet Cismoski and it's November 5th, 1996.
Q. Okay. Let's work from -- from that, Doctor. Sorry. Looks like there are maybe different records in different parts of the --
A. They may have been scanned differently or something.
Q. -- system. Got it. Okay. So let's turn to Suoja Medical 237, and I think you've already talked about this, but Mr. Suoja presents because he's feeling bloated. Is that right?
A. Yep.
Q. And at the bottom of the reason for the visit, there's a notation that talks about Mr. Suoja's diabetes. Do you see it?
A. The reason for visit?
Q. So there's a history of present illness?
A. Yes.
Q. And there's a full paragraph there?
A. Yep.
Q. And then the next paragraph starts with "Patient states that besides this, he is feeling well. He has occasional dizziness when he bends over and

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stands up too quickly, but this has been" --
A. Yep. Yep.
Q. -- present for the past several weeks"?
A. Yep.
Q. "He checks his blood sugar twice a day and they range between 96 to 270." What does that mean, Doctor?
A. So he does his blood pressure checks -- or excuse me -- his blood sugar checks and runs them with the -- his little blood sugar device, and he is assessing those to assess whether or not his -- his insulin is satisfactory.
Q. What -- what do the numbers 96 to 270 mean?
A. Well, it means that they're running wildly out of the -- you know, they're not being tightly managed. They're -- they're varying to -- with wide swings, so he's not managing them very tightly. So because he can't see, his wife is drawing up the insulin. As -- as it says there, he can't read the fine print on his insulin syringes, and so she is drawing up his insulin and they're mixing fast-acting and a -- and an intermediate-acting insulin to try and cover his immediate needs and then his slow -- slow needs over time.
Q. What happens when insulin levels or the blood

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sugar levels vary wildly?
A. Well, that adds to complications of diabetes and, you know, it makes -- it makes those complications much more likely, but -- but it takes long -- a long period of time for those kinds of swings to result in complications developing.
Q. And -- and, Doctor, just so I have an understanding, what -- what do you mean by a complication or complications?
A. Well, he already had the complications that had developed over a long time, so it means that his eyes had suffered the ravages of retinopathy, or the small vessel problems, and if it -- if it -- obviously that doesn't just happen very quickly. It takes a long time for those accrued issues of diabetes to -- to result in those kinds of complications, and the same is true for -- for other complications. You can minimize the risk of developing complications if you keep your blood sugar tightly controlled.
Q. Mr. Suoja developed blindness because of his diabetes?
A. Yes.
Q. Any other complications that you saw resulting from Mr. Suoja's diabetes?
A. No, not -- not that were obvious.

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Q. And you see the -- the note here that Mr. Suoja continues to be frustrated by his dependency on his wife due to his blind --
A. Yes.
Q. -- blindness, his appetite is good?
A. Yes.
Q. Is that true?
A. Yes.
Q. And then we're going to draw to the family history section, and what does the family history section tell us about Mr. Suoja?
A. Father died at age 68 with a myocardial infarction and asthma. Mother died with hypertension and a stroke. He had eight siblings. One child died of burns, one died of diptheria, one brother had pancreatic cancer, one sister had arthritis, and a brother died at a young age of uncertain causes. One brother is alive with some cerebrovascular disease and -- and an MI.
Q. You mentioned MI, or myo --
A. Myocardial infarction.
Q. Myocardial infarction. Is that a heart attack?
A. Yes.
Q. What's hypertension?

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A. High blood pressure.
Q. And what's diptheria?
A. Diptheria is a contagious disease that -- that used to ravage populations, particularly of the young, but -- but it's one of those childhood vaccinations that we get, you know, a DPT shot, so it's almost out of existence here in the western countries now, but it's still -- you know, as you can see here, it killed one of their children, and -- and so it still is terrible if you don't take -- prevent it.
Q. The -- it notes the brother had pancreatic cancer, which I take to mean cancer of the pancreas. Do you know the cause of pancreatic cancer?
A. Well, there are -- there have been many. There have been many things that have been associated with the development of pancreatic cancer, all the way from issues of smoking and chewing tobacco to alcohol ingestion and those kinds of things, so you name it, at one time or another it's been associated with -- possibly related to pancreatic cancer, so it's a bad -- it's also a bad disease. I -- I think, you know, it -- as you saw here. As you pointed out yourself here on Mr. Suoja's past history here, he says he continued -- his appetite is good here on

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November 5th -- on November 5th, and on December 13th, he was admitted with a complete bowel obstruction, so, you know, that's five weeks.

Q. The brother is alive with -- with -- I think it says cerebrovascular disease?

A. Yeah. So he has some evidence of probably -- whether he had a mild stroke or a TIA or something, he's got some kind of evidence that indicated that he has arterial sclerotic disease of the vessels leading to his brain.

Q. What's significant about -- both taking this family history of Mr. Suoja and what you understand would be pertinent to Mr. Suoja's own health?

A. Well, you know, Mr. Suoja himself is on some hydrochlorothiazide, so he's got a little touch of hypertension, although it hasn't been terribly out of control based on his blood pressure readings, and interestingly, none of his other relatives, siblings, or -- or children have been noted to -- in the family history to have diabetes, so he's the only one, so there isn't a family history here of diabetes, so it's -- it's not a -- yet at this point a Type 1 diabetes issue, or a -- or a family -- familial diabetes. He does clearly have Type 1 now at this point, but not familial. And -- and so he's just been

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one that developed the diabetes -- the one in the family that's developed the diabetes.

Q. What's the difference between the Type 1 and -- and familial or, I would take, Type 2 diabetes?

A. Well, Type 2 is acquired, so typically the -- the -- the patient who has developed secondary obesity and then, because of that, developed insulin resistance and now needs to have an exogenous source or an outside source of insulin because their own pancreas -- pancreatic insulin has just become insufficient to handle their body's needs.

Type 1 diabetes is a primary malfunction of the pancreas itself. So Type 2 is kind of acquired and Type 1 is -- is a primary. So you're -- the children that develop diabetes, childhood diabetes, would all be Type 1, and so on.

Q. And you -- and you see below under physical examination, the weight was 185 for Mr. Suoja. How would you characterize that weight?

A. Oh, I think that's a very reasonable weight and it's -- somewhere else it had been stated that that was pretty much unchanged, I think.

Q. Would a weight of 185 have any impact on -- on diabetes or whether it's Type 1 or Type 2?

A. No. That's pretty optimal weight, I would

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think. I mean, probably not if he was 4 foot 5, but, you know, he's -- he's -- nowhere is he described in any of these as being alert -- or I mean obese.

Q. And what does the note tell us about the social history for Mr. Suoja?

A. He's married with four children who are in good health. It does say that he and his wife frequently argue during the exam and he reports that she gets angry with him easily. If I -- if I had a dime for every family that I saw that way in the office over my years of practice, I -- I wouldn't have had to do any charging for my surgeries, I don't think.

(Laughter.)

Q. Under assessment, it lists one -- a number of items, but I want to make sure that I have an understanding of -- of the assessment. Number 1, chronic diarrhea with upper quadrant pain. You talked about that before. Is that right?

A. Yes. Yes.

Q. Number 2 is diabetes, Type 1, and you've talked about that before. Right?

A. Yeah. Yep.

Q. What's mild anemia?

A. So he has just a slight -- slightly low

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hemoglobin at 12.7, and I think as you saw in the physical exam, he's described as looking a bit pale. So, you know, it's not terribly abnormal sometimes in the elderly to see a slight anemia. Maybe they aren't eating quite right, maybe they aren't taking enough iron, you know, maybe -- maybe in a guy this age, maybe with some digestive complaints, maybe there's a colon cancer with -- with low -- with a little chronic blood loss from that colon cancer. There's a number of things you got to think of in the elderly with a low hemoglobin, so that's why it's put in there in the assessment: to chase -- chase down. And that's another reason why they included a colonoscopy in the workup.

Q. And what's a common term or layperson's term for anemia?

A. Well, gosh. I -- hm.

Q. Or would you just say someone's feeling anemic?

A. Yeah. Yeah. I guess -- you know, they're pale, they're a little ashen looking, they're -- they're -- you know, they're just not up to snuff. They're looking anemic. Yeah.

Q. And the next note is di -- diabetic retinopathy?

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A. Retinopathy.
Q. Retinopathy?
A. M-hm.
Q. Legally blind?
A. M-hm.
Q. And you've talked about that before?
A. M-hm.
Q. That Mr. Suoja was blind?
A. M-hm.
Q. It was caused by diabetes?
A. M-hm. Yep.
Q. The next is -- or what is number five?
A. Primary hypogonadism. So it's what we're all seeing all over the -- all over the advertising media today as low T, so it's -- it would be the elderly male who's got low testosterone, so it would be testicles that are a little undersized normal for that -- a male that age. Not unusual in the elderly, particularly in a male who's diabetic and -- and got a little chronic illness like that.
Q. What -- what would be secondary of -- of that history? Or what -- what -- what might somebody experience in their day-to-day life?
A. You know, a loss of energy, a little bit -- a loss of -- perhaps some mild depression, a little

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reduced physical capacity, weak -- some mild weakness.
Q. What's number six in the assessment, Doctor?
A. Primary hypothyroidism, so a low thyroid hormone level coming from the thyroid gland in the neck, and that's -- under treatment, he's on thyroid medication, so that's fully replaced by thyroid medication.
Q. What thyroid medication is he -- is he taking?
A. He's on Synthroid at a dose of 125 micrograms daily, so a -- that's a pretty common adult dose and it's -- it's a pretty common condition, really. Thyroid glands are one of those glands, those endocrine glands, again, that just sometimes can just kind of wear out, start to decrease their secretion, and they're the kind of gland that sets the rev, the -- the -- the idle speed for the body. So the thyroid hormone has -- if -- if you're feeling low in thy -- if you are low in this thyroid, then you're feeling generally weak and tired, and you may add a little weight, you get a little sluggish and obese, so everybody wants to automatically leap -- come to the doctor and say I'm weak, tired, and overweight and therefore I'm low in thyroid. But --
Q. I've got low T, I saw it on TV, Doctor?

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A. Yeah. That's right. Right.
Q. That's -- but you thought it was controlled here with a medication?
A. Yep.
Q. That's noted as Synthroid?
A. Synthroid, yeah.
Q. Synthroid? And what's under Synthroid in the medication?
A. Oh, let's see. Hydrochlorothiazide. That's a -- that's a diuretic for treating of high blood pressure. It's at a very modest dose, so his blood pressure is not very difficult to manage at all. And in the physical exam, his blood pressure, you know, most of ours -- we should all wish for blood pressure so good as he's got. If you look at his physical exam, his blood pressure taken and retaken in multiple situations -- both lying, sitting, and standing -- is all completely normal.
Q. And -- and turning back to the assessment, the note shows that Mr. Suoja had a history of TURP, or T-U-R-P?
A. Yes.
Q. That's --
A. Transurethral resection of the prostate gland, so he had an enlarged prostate way back in

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1984, 12 years before the time this exam was done, so he had a transurethral prostate resection done through the urethroscope, so not an open incision but done with a scope through the urethra, and -- and so that made his voiding pattern easier. Symptoms of that would be prostate -- big prostate would be difficult urination, frequency of urination at night, slow stream, and so on. And recently he'd been complaining of urinary hesitancy, which means you feel the urge to go but then you can't get started.
Q. Ah. Under the physical examination, it notes that Mr. Suoja used a cane for ambulation on the second to the last line of the physical examination. Why is that, Doctor?
A. Well, I suspect, you know -- it says just before that that his gait was steady and coordinated. I -- I -- you know, I'm -- I'm totally reading into this and this may not be valid, as you've pointed out several times before in this deposition, but, you know, he's blind, so maybe he uses it to just make sure he's steady and to make sure that if he does bump into something, he does it with the cane first and not his -- not his shin, not his leg, not his foot, and just to make sure that he stays steady.
Q. Did Mr. Suoja have any comorbidities?

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A. Comorbidities. Well, of course, he's blind from his -- from his diabetes.
Q. Diabetes?
A. That certainly would be considered a comorbidity. That's a -- that's a big red flag in today's world in terms of potential risks at home. The risk of falls would be great in a patient who is considered legally blind. That raises your risk for -- for degree of illness -- injury score; that goes way up. His diabetes, you know, is -- is a risk factor for any number of different illnesses, conditions, and -- and, you know, complicating other things. Anytime he -- they come in for any kind of procedure, even -- even our procedure, with a laparoscopy, you know, watching their diabetes gets really dicey, because you have to -- you have to watch their sugars much more tightly. You kind of throw their eating off and, you know, I think it's -- it's -- you know, he's had diarrhea, so how much is he absorbing the food that he eats, and yet if he's on his usual dose of insulin, maybe they're still giving him the right dose -- the usual, customary dose of insulin but maybe he's not absorbing his food as much because of his chronic diarrhea so, you know, he's at risk for hypoglycemic attacks because, you know,

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they're -- they're dosing him at his usual insulin but he's not getting the same carbo load, that kind of thing. So he has lots of -- he has a number of comorbidities.
Q. And would those affect Mr. Suoja's day-to-day life, sort of his quality of life in every given day?
A. Sure, and that certainly may be leading to his sense of kind of life's dissatisfaction and his anger level and frustration and, you know, his easy -- his cantankerousness.
Q. Doctor, I have a -- what's called a Rule 26 report prepared by counsel for Thomas Wiig dated August 13th, 2012. Just to ask you generally, have you ever seen that document before?
A. Not that I recall.
Q. Did plaintiff's counsel confer with you at all in preparing a report about the facts and opinions that you might provide in this case?
MR. McCOY: I'm going to object to the characterization of that as a -- as a report, and that's properly within the scope of the rules to make that disclosure for a treating physician. You can go ahead and answer, Doctor.
A. So re -- could you repeat the question?
Q. Sure. Sure, Doctor. Did plaintiff's counsel

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talk with you at all about the facts, opinions, or what you would be expected to testify about in preparing the Rule 26 report that was provided in this case?
A. No.
Q. And it's dated August 13, 2012. Have you even talked to plaintiff's counsel before August 13, 2012, or on August 13, 2012?
A. No.
Q. And this lawsuit was filed in 1999. When, again, Doctor, was the first time that you had heard anything about this case?
A. October 29th, 2015.
Q. Doctor, I think that's all the questions I have for you today. I do appreciate your patience in going through the -- the records with both Mr. McCoy and myself.
A. Okay.
FURTHER EXAMINATION
BY MR. McCOY:
Q. Doctor, I just have a couple brief follow-up questions. If you need a break, fine. I don't think this will take more than two minutes here.
A. No. Go ahead.
Q. Okay. Let me go ahead then. First off,

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there was a reference in the examination by Mr. Watson to histochemical staining being required to diagnose mesothelioma. Was this done for Mr. Suoja's case?
A. Yes.
Q. And who did that?
A. Dr. Henke.
Q. He's the --
A. The pathologist.
Q. The path -- okay. And he's the one who normally does the histochemical staining when it's required for a cancer diagnosis? He's one of the people. Correct?
A. Well, he -- it's done under his direction. If you're asking does he physically do it himself, no, the -- but he directs the lab personnel to do that and then he follows through with reading the assessments that are the result of the staining.
Q. And just as a general question, the two sets of exhibits that you had received from -- from my office, those are records from the care and treatment of Mr. Suoja. Right?
A. Yes.
Q. The other question I have is there was some -- some mention about the pain medications, I think. Can you briefly describe for us the regimen of

pain medication that Mr. Suoja received during his care and treatment starting with the visit back in September of -- of 1996, September 10th?

MR. WATSON: Objection; form, foundation, cumulative. The witness has already testified about this.

A. Well, I think that initially, he wasn't changed to -- or he wasn't placed on any, back in September, new or different pain medication regimens. It was felt that some of his symptomatology might be due to some overgrowth of abnormal bacteria due to some bowel sluggishness, diabetic-related, and so he was placed on a course of some intestinal antibiotics looking to try and treat intestinal overgrowth of abnormal bacteria to try to get his bacteria back in the proper alignment and balance.

But after the surgery, my laparoscopic surgery, he was placed on oral medications, oral opioid medications, for the purposes of controlling his acute postoperative pain; and by the time, then, that he came back in with his bowel obstruction, he had basically lost the ability to re -- take and retain his oral medications and so they were increasingly unreliable and so he was changed to patches, which are absorbed through the skin, and so

he was placed on Duragesic patches, which are time-released and give a more reliable and more appropriate long-term pain control format rather than the peaks and valleys of the oral tablets are able to.

And then after he was discharged for his brief time back home from home hospice, he was actually using some of their IV morphine regimens, so he did in fact sort of pretty quickly march along the -- the pathway of increasing intensity of opioid pain management. That's pretty common for hospice-type patients.

Q. Those are all the questions I have, Doctor. Thank you.

A. Okay. Thank you.

MR. McCOY: We -- as far as -- I think we can let the doctor go now. Right, Brian?

MR. WATSON: The only question is, Doctor, whether you'd like to read -- read the transcript and sign it or whether you're waiving signature and the ability to review the transcript.

THE WITNESS: I'll waive.

MR. McCOY: I think that's -- okay. Well, thank you very much, Doctor. I think -- I just want to make sure that the court reporter -- we arrange all the exhibits, so you can go ahead and I'll

stay on the line for a moment with Brian and the court reporter.

THE WITNESS: Okay. Thank you.

MR. WATSON: Thank you, Doctor. Have a great night.

(Discussion off the record.)

(The deposition concluded at 4:50 p.m.)

(Dr. Wiig Exhibit 1 was marked for identification.)

C E R T I F I C A T E

I, Karen J. Macaulay, hereby certify that I am qualified as a verbatim shorthand reporter;

That I took in stenographic shorthand the deposition under oath of THOMAS WIIG, M.D., at the time and place aforesaid;

That the foregoing transcript is a true and correct, full and complete transcription of the testimony of this witness, to the best of my ability;

That the review of the transcript was waived;

That I am not a relative or employee of any of the parties or a relative or employee of any of the attorneys;

That I have no interest, financial or otherwise, in this action and have no contract with the parties or attorneys or persons with an interest in this action.

Witness my hand and seal this 30th day of November, 2015.

KAREN J. MACAULAY, RDR
Registered Diplomate Reporter
Notary Public
Carlton County, Minnesota

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